RUPTURE OF THE URETHRA

Trauma to the urethra usually involves the bulbomembranous portion, sustained as a result of a blow to the perineum or falling astride some hard object, the so-called "straddle injury."

With rupture of the urethra and inability on the part of the patient to void, immediate treatment is imperative. If by gentle manipulation it is impossible to catheterize the patient, suprapubic cystotomy should be performed immediately. Cystotomy is the sheet anchor in the treatment of these cases as well as in impassable strictures. If the patient is in extremis, one should be content with cystostomy alone, and the second stage of the operation completed at a later date. Extravasation of urine and blood should of course be adequately drained by incisions of the involved areas at the first stage.

The second stage of the operation involves reëstablishment of the continuity of the urethra. The use of the Davis interlocking sounds (Fig. 1) provides the ideal solution of this problem. The female portion of the sound (b) is passed into the bladder through the cystotomy wound and guided into the prostatic urethra with the aid of the index finger until it meets the male sound (a) passed through the anterior urethra. The male sound is then passed easily on into the bladder, a catheter is tied to it and it is withdrawn, leaving the catheter in place for permanent drainage. The retention catheter is left in situ for about a week or ten days and then removed. Sounds are subsequently passed at intervals to preserve the urethral lumen and prevent stricture formation.

IMPASSABLE STRICTURE OF THE URETHRA

Strictures of the urethra are in general either (1) traumatic in origin, or (2) inflammatory. Most inflammatory strictures are of gonorrheal origin. Practically all impassable strictures, whether traumatic or inflammatory in origin, are located in the bulbomembranous urethra. Strictures of the urethra which cannot be dilated satisfactorily with sounds but which permit the passage of filiforms and followers to the bladder may be cut with the urethrotome (internal urethrotomy). Impassable strictures are best treated with the Davis interlocking sound technique exactly as described above for rupture of the urethra. In many cases, the strictured area may be so resistant that the interlocking sounds cannot be readily approximated. In that event, the following procedure is carried out: The patient is placed in lithotomy position and both the suprapubic and perineal regions are surgically prepared. The Davis interlocking sounds are approximated as nearly as possible and held in place by an assistant. The surgeon then can readily palpate the end of each sound through the perineum. The ends may be one to three centimeters apart as a result of the dense intervening urethral stricture. A small midline perineal incision is made between the ends of the sounds and the strictured area excised, thus permitting the two sounds to come together. The operation is then completed as described above for rupture of the urethra. A retention catheter is drawn in place through the urethra and permanent drainage maintained for ten days or two weeks. No sutures are necessary to approximate the severed ends of the urethral mucosa. Nature amply provides the necessary union about the catheter as a guide.

Considerable practical experience with this procedure has given convincing proof of its value as compared with the tedious and difficult perineal dissections that have hitherto been made in attempts to restore the continuity of the urethra.

CONCLUSIONS

A simple procedure applicable alike to the treatment of rupture of the urethra, and impassable stricture of the urethra, is described which practical experience has shown to be highly successful. These remarks may be interpreted as a testimonial to the Davis interlocking sounds, and rightly so, because they have brought order out of chaos and make it possible for the general practitioner as well as the specialist to manage these hitherto difficult cases with greater ease and success with a consequent reduction in morbidity and mortality rates.

450 Sutter Street.

A PSYCHIATRIST-AT-LARGE IN JAPAN*

Z. M. L.
Japan

ON a recent trip to Tokyo, about a month after the occupation, I had an unusual opportunity to visit a Japanese medical school and teaching hospital. Our interpreter and guide was an excessively polite and immature looking college student named Taro. He had agreed to take us to Keio University Medical School where his cousin was in his third year. Keio University houses one of the seven large medical schools in Tokyo and is located in a section called Yotsuya, about five miles from the center of the city in a semi-residential district.

As we entered the grounds we noticed that many of the buildings had been damaged or destroyed. We were later informed that a third of their buildings, including the section for first class patients had been burned to the ground. Another third was seriously damaged and the remaining third was untouched. We were ushered into the library building, a memorial to one of their distinguished alumni, and introduced to Dr. S. Uiematsu, Professor of Neurology and Psychiatry and a graduate of Harvard University Medical School, class of 1922. It was shortly after twelve noon and the faculty was just finishing lunch in a large conference room, richly paneled in dark wood. Professor Uiematsu introduced us to the rest of the faculty and apologized for the absence of the dean who was out of the city. He showed us to chairs in an adjoining reception room and invited us to have luncheon. Being aware of the serious food shortage in Japan we declined his hospitable gesture, but he called for a pot of Japanese tea in which we all joined. In turn we offered him some American cigarettes which he smoked with obvious relish.

The professor was a small, serious man of about 50 years, with a tiny moustache and greying hair. He wore the conventional thick glasses and was dressed in a conservative tweed of American cut. His English was a bit slow and soft spoken, but his choice of words was exact. He spoke of his psychiatric training under the late Dr. Macfie Campbell with more than a trace of nostalgia. He looked rather subdued and sad as if to imply that the happenings of the last ten years were not of his choosing. He was very dignified, attentive, and polite to us as visitors, but there was none of the fawning and obsequious behavior which appears to be so prevalent among the conquered Nazis. We talked as colleagues and he answered all questions willingly and apparently without reserve.

We spoke first of psychiatry. He told us that the Japanese psychiatrists had anticipated a large number of psychiatric casualties following the B-29 bombing raids. They received only one-half the estimated number among the civilian population. (This is strikingly similar to the British experience as reported by Col. Gillespie.) There

* The letter that follows was received by CALIFORNIA AND WESTERN MEDICINE from a friend in the U. S. Navy. Its interesting observations explain its appearance in this department.—Ed.

has been no relative increase in the incidence of psychoses in either the civilian population or in the Armed Forces. This, too, appears to be a universal experience. When I inquired about the incidence of psychoneuroses in the Armed Forces he smiled wryly and stated that, of course, they occur, but are not called by that name for reasons of military expediency. He felt that there was perhaps a slight increase in the incidence of general paresis during the war but practically no other changes in the incidence of psychiatric illnesses.

The Japanese have been familiar with all the recent forms of shock therapy and are still using insulin in schizophrenia, particularly in the catatonic form. When I asked if he followed the Sakel technique he seemed to be unfamiliar with the name and did not know that Sakel had introduced insulin shock therapy over ten years ago. This was explained by the fact that all the recent European medical literature available in Japan was of Nazi origin. Since Sakel was a Viennese Jew, his name had apparently been carefully deleted from all the literature on insulin therapy. Prof. Uiematsu mentioned that the Japanese had been using an insulin derived from fish pancreas which was found to be very effective in producing hypoglycemia. This is not too surprising when it is remembered that Japan is not a meat-eating country but depends chiefly on fish for its animal protein.

Metrazol (or Cardiazol, as it is known in Japan) was used in 1938 and 1939, but for the last five years electroshock therapy has been employed. It is still being used with considerable success in the treatment of the depressions. On inquiring further, I learned that all treatments are given in hospitals; none is given in homes or out-patient clinics. Curare has not been used to cushion the shock of the convulsion and, in fact, he was ignorant of its use in this regard.

Prefrontal lobotomy has been performed on a large series of cases by Dr. Nakada of Niigata University Medical School. Many of the patients were, surprisingly enough, manic-depressives in the manic phase. His results were apparently encouraging enough for him to continue with the operation. He uses the lateral approach with a simplified leucotome, similar to that used by Freeman and Watts.

Psychoanalysis has apparently had very little following in Japan. Prof. Uiematsu could think of only one psychiatrist practicing analysis. This psychiatrist had also studied in the United States with Dr. Adolph Meyer shortly after World War I, and is still practicing in Tokyo.

I asked Prof. Uiematsu about his experience with sodium amytal or pentothal narcotherapy. Not only had he never used it, but he was quite unaware of its value in military and civilian psychiatry. He exhibited great interest in the subject and I referred him to a few of the leading articles in some of the American journals to which he might soon have access and he was very grateful.

We also questioned the professor on more general medical topics. He said that malnutrition was Japan's pressing problem. Despite this, there were very few cases of beriberi and practically no cases of deficiency polyneuritis. This is eloquent testimony to the efficacy of the governmental edicts insisting on the use of unpolished rice in the diet. Tuberculosis is definitely on the increase and postoperative wound infections are numerous because of the decreased resistance of the patient and the breakdown in aseptic techniques in the under-staffed and bomb-shattered hospitals.

Prof. Uiematsu next showed us through the Keio University Hospital which is the teaching hospital in direct connection with the medical school. They used to take in three classes of patients but now have facilities for only the lower two classes since the building that housed the first class patients was destroyed. The 3rd class patients pay 4 yen (about 60c) per day and the 2nd class patients pay 8 to 10 yen. Despite a large number of white gowned orderlies and nurses, the floors and walls of the 3rd class section were filthy and the ward smelled badly. Some one had started to burn some fragrant charcoal in a porcelain urn but this did not help matters appreciably. Each bed was separated from its neighbor by dirty white sheets which were kept draped about the bed all day, giving each patient a certain amount of privacy. The relatives of the patients who were present in large numbers were either hovering anxiously about the patient, or running up and down the narrow corridors on various errands adding immeasurably to the confusion. The beds were of the standard hospital type, but in each cubicle the patient usually had some prized household *objet d'art* —a doll, a figurine, or some treasured possession—on a prominent place near him.

In the large tiled bathroom and toilet (only one on each floor for both sexes) we found a Japanese woman busily engaged in building a twig fire on the floor to warm some home-made food she had brought for one of her relatives. This practice is no longer uncommon and, in fact, is encouraged by the hospital since it is almost impossible for the institution to scrape together enough food to feed its patients adequately. The washroom was large and well designed, but was suffering from neglect. The toilets or "benjos" were of the characteristic Japanese variety, built almost flush with the floor and shaped like a miniature porcelain gondola with a splash-proof prow. In Japan one must be able to squat with agility and accuracy.

We were taken next to the psychiatric wing for 2nd class patients, the only facilities remaining. There was room for about twenty patients but only ten rooms were occupied. These were quite elegant in comparison with the accommodations for the 3rd class patients. Each patient had a large private room which appeared to be decorated and arranged according to the individual taste of the occupant or one of his relatives. A large section of the room was raised about 8 inches to make a platform which was covered with finely woven straw matting. Part of this raised platform was used as a bed by the patient, who lay covered with beautiful thick comforters in richly colored silks. Some of the patients had their own furniture moved in to make things more "homey." A distinguished and elaborately robed man of 50 years sat cross-legged on the floor in front of an ornate kakemono scroll; a case of pre-senile psychosis. A lady in a room across the hall lay in bed completely mute, her unseeing eyes fixed in the typical expression of catatonia. A third patient in his 50's was being treated for general paresis by typhoid injections. Therapeutic malaria is usually employed, but in this case Prof. Uiematsu felt that the patient was too old and feeble to withstand such rigorous treatment.

We made a brief tour of the remaining parts of the hospital. The laboratory was a large but poorly kept room full of dirty glassware and antiquated apparatus. In one corner were several bottles of mold-covered urine which had apparently been standing for days. Everything looked run down, dirty and neglected. The pharmacy contained a few glass jars of old drugs and herbs. Even these were meagre in quantity and the doctor complained bitterly that it was almost impossible to get essential drugs and medications. I commented that the caves honeycombing the hills near the Japanese Naval Hospital at Yokosuka were crammed to the top with fine instruments and drugs, mostly of German manufacture. He smiled sadly and said, "Ah yes, for the military there was never any shortage." The large operating room contained two tables

of fairly modern design, but the wall plaster was badly cracked and huge flakes of old paint threatened to fall from the ceiling. The x-ray equipment was all antiquated and it was impossible to get replacements for worn parts.

As we walked down the stairs, we noticed that all the metal treads had been removed from the edges of the terrazzo steps. When I inquired about the reason for this, the professor smiled and said quite slowly, "They went into our last big scrap drive—over a year ago!"

Japan, December 3, 1945.

CLINICAL NOTES AND CASE REPORTS

FOOT STRAIN: A VALUABLE SIGN

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THE following is a simple test for the diagnosis of foot strain. Although the sign is well known among orthopedists, other practitioners are generally not familiar with it. Tenderness is felt over the center of the medial border of the longitudinal arch. If pain is present on moderate pressure here a diagnosis of foot strain can usually be made.

It may seem presumptuous to mention so simple a test. The clinical value of the sign has nevertheless not been sufficiently emphasized. The diagnosis of foot strain is often difficult to make. Indeed it is frequently made by exclusion. The examiner eliminates the possibility of peripheral vascular disease, of inflammatory disease and of trauma, and thus static strain is left as the cause of the patient's painful feet. It is evident that if a positive sign for the diagnosis of foot strain could be made rather than a diagnosis by exclusion we would have a more conclusive diagnosis. The presence of valgus deformity of the foot is itself insufficient evidence for a diagnosis of foot strain. Anyone who has examined many human feet has noted many flat feet that caused no symptoms. Therefore, a patient may have flat feet, yet the pain in his feet is not necessarily a result of the deformity. Furthermore, he may have pain in his legs or pain in his back without any pain directly in his foot, and yet all his symptoms may be caused by foot strain. What is the cause of this tenderness in the center of the inner border of the foot? In this area the tendons of insertion of both the Tibialis Anticus and of Tibialis Posticus are very superficial. On dissection of the insertions of these two tendons one will find the tendoosseaus junction surrounded by thin connective tissue having the appearance of a bursa. This filmy connective tissue is both superficial to and deep to the tendinous insertion, and it is probable that this tissue undergoes slight non-specific inflammatory changes. Why should there be irritation at the insertion of these two tendons, the Tibialis Anticus and Tibialis Posticus? Because the entire weight of the body with each step stretches the tendinous insertion. Because the tendons can be easily pressed and irritated between the tarsus and the shoe. (Illustrations of cross sections of the tarsus, appearing in volumes on anatomy, show the superficial position of the tendons of the tibialis anterioris and posterioris.)

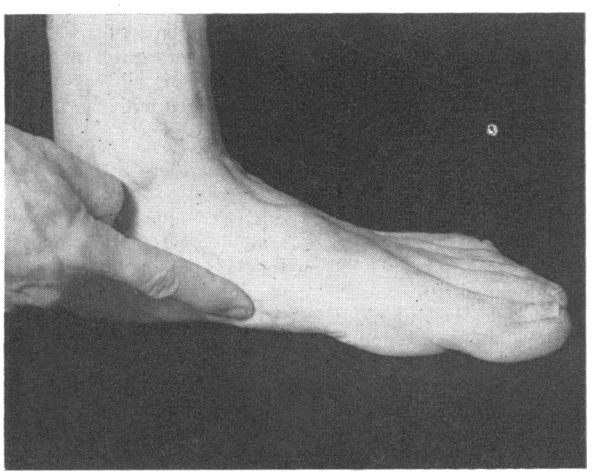

Fig. 1.—Palpation for tenderness to determine presence of strain.

The feet of twenty individuals were used as controls. These twenty adults had no complaints referable to their extremities or to their back. In none of these twenty people was any tenderness present on pressure over the medial border of the foot.

SUMMARY

A simple test for foot strain is emphasized. It consists of point tenderness over the center of the inner border of the tarsal area.

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OBSCURE LYMPHOSARCOMA

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THIS case is reported not only because it seems to offer a fair opportunity to correlate changes in the differential blood count with the x-ray therapy administered but also to raise a question concerning therapeutic procedure under similar circumstances.

REPORT OF CASE

A white female of 53 years, presented herself with multiple nodular swellings in the neck, axillae and groins and a complaint of generalized abdominal pain and swelling which followed a fall on the abdomen two months previously. She had lost 20 pounds during this two months. She was found to have a left post-pharyngeal swelling, generalized discrete lymphadenopathy and a palpable tender spleen. The lymph nodes were only moderately enlarged. The initial blood count showed 10,150 WBC with 64 per cent lymphocytes, equivalent to about 6,500 lymphocytes per cu. mm. Normally with a 10,000 cell count and a maximum of 35 per cent lymphocytes we would see that 3,500 would be about the high level of normal. Thus her circulating lymphocytes were not quite double the figure but no immature forms were recognized.

An inguinal node was removed for study and findings reported "compatible with leukemic lymphadenosis but they do not warrant a diagnosis of lymphosarcoma."

X-ray therapy was given on the basis of the tissue diagnosis, treating the spleen, both sides of the neck, both axillae and both groins in a system of rotation. Five days after 100 r over the spleen the circulating lymphocytes had dropped from 6,500 to 1,600 per cu. mm.—a rather dramatic change. Four days later, however, this low figure had more than doubled to 3,535 per cu. mm., but at no time subsequently did it ever significantly exceed this figure.

During the first four months a total of 1,500 r were given, 300 r of this over the spleen. At four and one-half months a sudden reversal in the differential count occurred. Nine counts during the initial period had shown an average of 60 per cent of the circulating white blood cells to be lymphocytes. Fourteen counts during the next year and one-half showed an average of only 33 per cent. At one time a year after treatment was instituted the treated glands had disappeared and the intern who saw the patient in good condition in the clinic recorded that